| STATEME AND PLAN | NT OF DEFICIENCIES NOF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 | | | OMB NO. 0938- (X3) DATE SURVE COMPLETED | |
|---------------------|--------------------------------------|--|---|-------|---|---|--|
| | | 445017 | B. WING_ | | | | |
| NAME O | F PROVIDER OR SUPPLIER | | | STRE | ET ADDRESS, CITY, STATE, ZIP CODE | 06/06/201 | |
| ASRUR | Y PLACE AT MARYVIL | 1.5 | ł | | SEVIERVILLE RD | | |
| | CAOL AI MARIVIL | .L.C. | | | YVILLE, TN 37804 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | | | | | |
| PRÉFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) | TRE COMPLE | |
| K 000 | INITIAL COMMENT | -s | K 00 | 0 | K 222- Egress Doors | f | |
| | A life cafety susyay | uma aanalustad ku lii . | | 1 | . What corrective action(s) will b | | |
| | Tennessee Departm | was conducted by the state of eent of Health, Division of | | | accomplished for those residen | ie . r | |
| | health licensure and | regulation office of health | | | found to have been affected by | $7/_{27}$ | |
| | care facilities on6/5 | & 6/6/17. During this life | | | the deficient practice? | 201 | |
| | safety survey, Asbui | Place Marvville was not | | | manufactive practice: | UN | |
| | tound to be in substi | antial compliance with the | | | It is the facilities practice to ensu | Iro. | |
| | requirements for par | ticipation in | | | that we maintain delayed egress | ure | |
| | Medicare/Medicaid a | at 42 CFR Subpart 483.70(a), | | | doors having the required signag | , | |
| | Life safety from fire. | and the related National Fire | | | for 2 of 21 smoke compartments | ; c | |
| | Protection Association | on (NFPA) standard 101 - | | | The facility ordered the | . . | |
| | 2012 edition. | | | | appropriate egress signage for ex | vi+ | |
| | The requirement at 4 | IO OFF | | | by room 102 and the first floor | αι | |
| | NOT MET as eviden | 12 CFR, Subpart 483.70(a) is | | | living room on 6/6/2017.The sign | | |
| K 222 | NFPA 101 Egress Do | ced by. | | | will be installed by 6/30/17. | ıa | |
| SS=D | Control Egicas D(| JOIS | K 222 | | 3 13 13 14 15 15 15 15 15 15 15 15 15 15 15 15 15 | | |
| | Egress Doors | | | 2. | How you will identify other | | |
| | Doors in a required n | neans of egress shall not be | | | residents having the potential to | 1 | |
| | equipped with a latch | or a lock that requires the | | | be affected by the same deficien | t | |
| | use of a tool or key fr | om the earess side unless | | | practice and what corrective | - | |
| | using one of the follow | wing special locking | | | action will be taken. | | |
| | arrangements: | | | | | | |
| | CLINICAL NEEDS OF | R SECURITY THREAT | | | All other Delayed egress doors | | |
| | LOCKING | | | | were checked by the facilities | | |
| | clinical special tocking | g arrangements for the | | | director on 6/6/2017 to insure | | |
| | only one locking device | of the patient are used, | | | proper egress signage, 100% | | |
| | each door and provise | ce shall be permitted on one shall be made for the | | | compliance was noted for other | | |
| | rapid removal of occur | pants by: remote control of | | | doors. The doors needing delayed | | |
| | locks; keving of all loc | ks or keys carried by staff at | | | egress signage were installed on | | |
| | all times; or other suc | h reliable means available | | | 6/9/2017 | | |
| | to the staff at all times | 5. | | | | | |
| | 18.2.2.2.5.1, 18.2.2.2. | 6, 19.2.2.2.5.1, 19.2.2.2.6 | | | | | |
| | SPECIAL NEEDS LO | CKING ARRANGEMENTS | | 3. | What measures will be put into | | |
| , | vvnere special locking | arrangements for the | | | place or what systematic changes | | |
| ; | safety needs of the pa | itient are used, all of the | | | you will make to ensure that the | | |
| ' | Clinical or Security Lo | cking requirements are | | | deficient practice does not recur. | | |
| RATORY I | DIRECTOR'S OR PROVIDER | SUPPLIER REPRESENTATIVE'S SIGNATI | IDC | | | | |
| MAR | Lan Di | A STATE OF THE PROPERTY OF THE | J:1E | | TITLE | (X6) DATE | |
| eficiency | statement ending with | LNHA | · | | be excused from correcting providing it is | 21/17 | |
| safequer | de provide aufficient essenti | iscrisk (*) denotes a deficiency which t | he institution | n may | be excused from correcting providing it is homes, the findings stated above are dis | datarmina d shak | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I4YY21

LN HA
Facility ID: TN0505

Material Region 1 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/08/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 445017 B. WING 06/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ASBURY PLACE AT MARYVILLE 2648 SEVIERVILLE RD MARYVILLE, TN 37804 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR USC (DENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) K 222 Continued From page 1 The Facilities Director will educate K 222 being met. In addition, the locks must be all maintenance staff regarding electrical locks that fail safely so as to release regulations for egress doors and upon loss of power to the device; the building is how to inspect them by June 30, protected by a supervised automatic sprinkler 2017. system and the locked space is protected by a complete smoke detection system (or is How the corrective action(s) will constantly monitored at an attended location be monitored to ensure the within the locked space); and both the sprinkler deficient practice will not recur; and detection systems are arranged to unlock the i.e. what quality assurance doors upon activation. program will be put into place. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING All signage will be checked monthly ARRANGEMENTS on an ongoing basis as part of our Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be routine inspection schedule, by the permitted on door assemblies serving low and facility director or maintenance ordinary hazard contents in buildings protected assistant. The results of the throughout by an approved, supervised automatic monthly checks will be reported to fire detection system or an approved, supervised QAPI committee x 3 months. automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING K 281 Illumination of Means of K281 ARRANGEMENTS Egress Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be 1. What corrective action(s) will be permitted. accomplished for those residents 18.2.2.2.4, 19.2.2,2,4 found to have been affected by ELEVATOR LOBBY EXIT ACCESS LOCKING the deficient practice? ARRANGEMENTS Elevator lobby exit access door locking in It is the facilities practice to ensure accordance with 7.2.1.6.3 shall be permitted on exit discharges is provided with door assemblies in buildings protected throughout illumination that affects 6 of 21 by an approved, supervised automatic fire detection system and an approved, supervised smoke compartments. automatic sprinkler system. A bid was received on 6/9/2017 to 18.2.2.2.4, 19.2.2.2.4 ensure exit discharge illumination This STANDARD is not met as evidenced by: will be provided at the two exit Based on observation and interview, the facility discharge stairwells on the west failed to maintain delayed egress doors. This side of the facility. Installation of FORM CMS-2567(02-99) Previous Versions Obsolete proper illumination on the exit Event ID: I4YY21 Facility. sheet Page 2 of 10 doors on the west side of the facility will be installed on

6/30/2017.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/08/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 445017 B. WING NAME OF PROVIDER OR SUPPLIER 06/06/2017 STREET ADDRESS, CITY, STATE, ZIP CODE ASBURY PLACE AT MARYVILLE 2648 SEVIERVILLE RD MARYVILLE, TN 37804 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE 2. How you will identify other K 222 Continued From page 2 K 222 residents having the potential to deficiency affected 2 of 21 smoke compartments. be affected by the same deficient 281 practice and what corrective NFPA 101, 19.2.2.2 action will be taken. NFPA 101, 7.2.1.6.1 100% compliance was noted for The findings include: other 15 exit discharge doors. Observation and interview with the maintenance Installation of proper illumination director 6/5/17 at 8:10 PM revealed delayed on the exit doors on the west side egress doors by room 102 and first floor living of the facility will be installed on room did not have the required signage. 6/30/2017. The maintenance director was present when the deficiencies were identified and acknowledged by 3. What measures will be put into the administrator during the exit conference on place or what systematic changes 6/6/17. you will make to ensure that the K 281 NFPA 101 Illumination of Means of Egress K 281 deficient practice does not recur. SS=E Illumination of Means of Egress The Facilities Director will educate Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and all maintenance staff regarding shall be either continuously in operation or regulations for exit discharge capable of automatic operation without manual illumination and how to inspect intervention. them by June 30, 2017. 18.2.8, 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility 4. How the corrective action(s) will failed to ensure exit discharges were provided be monitored to ensure the with illumination. This deficiency affected 6 of 21 smoke compartments. deficient practice will not recur: i.e. what quality assurance NFPA 101, 19.7.6, 19.2.8 program will be put into place. The findings include:

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Observation and interview with the maintenance

director on 6/5/17 10:00 PM and 10:39 PM

revealed the exit discharges from the two

Event ID: i4YY21

Facility ID: 1

The results of the monthly checks
will be reported to QAPI monthly x: sheet Page 3 of 10
3 months.

All exit discharge illumination will be checked monthly on an ongoing

inspection schedule, by the facility

director or maintenance assistant.

basis as part of our routine

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/08/2017 FORM APPROVED

| STATEMEN | NT OF DEFICIENCIES | CAN DOOMING DISCOURS | - | | | 0 | MB NO. 0938 | -039 |
|--------------------------|--|--|-------------------|---------------|----|--|-----------------------------|----------|
| AND PLAN | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER: | | | | STRUCTION AIN BUILDING 01 | (X3) DATE SURV COMPLETED | ΈY |
| | | 445017 | B. WING | ; | | | DEIDEIDA | 47 |
| ! | PROVIDER OR SUPPLIER Y PLACE AT MARYVIL | LE | | 2648 | SE | ADDRESS, CITY, STATE, ZIP CODE VIERVILLE RD ILLE, TN 37804 | 06/06/201 | 17 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | CF | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLE | ETION |
| K 281 | Continued From page | ge 3 | K 2 | 81 | | K 324 Cooking Facilities | | |
| | stairwells on the we have egress illumina The maintenance di deficiencies were ide | st side of the facility did not | 32 | | 1. | What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice? | 1/2Z | /17 } |
| K 324 SS=E | 6/6/17. NFPA 101 Cooking I | | К3 | 24 | | It is the facilities practice to provide required fire extinguish that open to the corridor using | ers | |
| | and Fire Protection of Operations, unless: * residential cooking appliances such as residential cooking appliances such as residential cooking in accordance tooking in accordance tooking facilities on | is protected in accordance lard for Ventilation Control of Commercial Cooking equipment (i.e., small microwaves, hot plates, or food warming or limited be with 18.3.2.5.2, 19.3.2.5.2 been to the corridor in smoke | | | | cooking facilities that affect 3 o smoke compartments. The facil ordered 3 fire extinguishers on 6/9/2017 for the cooking facilit open to the corridor on 2 North and 3 North and installed them 6/16/17. | ies 1 | |
| | with the conditions ur or * cooking facilities in: 30 or fewer patients of 18.3.2.5.4, 19.3.2.5.4 Cooking facilities protection of the per 9.2.3 are not required areas, but corridor. 18.3.2.5.1 through 18.3.2.5.5, 9.2.3, TIA This STANDARD is no Based on observation. | tected according to NFPA 96 sired to be enclosed as shall not be open to the .3.2.5.4, 19.3.2.5.1 through 12-2 ot met as evidenced by: | | | 2. | How you will identify other residents having the potential be affected by the same deficie practice and what corrective action will be taken. After checking 100% of the coofacilities open to the corridor, where the confidence of the corridor using cooking facilities. Fire extinguisher that opens to corridor using cooking facilities fire extinguishers were installed each of the 3 cooking facilities open to the corridor on 6/16/2 | king ve h a the | |
| | alled to provide requir | red fire extinguishers. This | | | 3. | | | - |
| 0.810-2007 | desast metions versions Ope | solete Event ID: MYY21 | Fa | acility ID: 1 | ł | place or what systematic chan you will make to ensure that t | | 10 |

deficient practice does not recur.

The Facilities Director will educate all maintenance staff regarding regulations for kitchen fire extinguisher placement and how to inspect them by June 30, 2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 06/08/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 445017 8. WING NAME OF PROVIDER OR SUPPLIER 06/06/2017 STREET ADDRESS, CITY, STATE, ZIP CODE ASBURY PLACE AT MARYVILLE 2648 SEVIERVILLE RD MARYVILLE, TN 37804 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 324 Continued From page 4 How the corrective action(s) will K 324 be monitored to ensure the deficiency affected 3 of 21 smoke compartments. deficient practice will not recur; i.e. what quality assurance NFPA 101, 19.7.6 program will be put into place. NFPA 19.3.2.5.3(8) Observation and interview with the maintenance All cooking facilities open to the director on 6/5/17 between 9:51 PM and 10:30 corridor will be checked monthly PM revealed the cooking facilities open to the on an ongoing basis as part of our corridor on 2 North and 3 North were not provided routine inspection schedule, by the with fire extinguishers. facility director or maintenance The maintenance director was present when the assistant. The results of the deficiencies were identified and acknowledged by monthly checks will be reported to the administrator during the exit conference on QAPI committee x 3 months. 6/6/17. K 353 NFPA 101 Sprinkler System - Maintenance and K 353 K 353 Sprinkler System SS=D Testing Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are 1. What corrective action(s) will be inspected, tested, and maintained in accordance accomplished for those residents with NFPA 25, Standard for the Inspection, found to have been affected by Testing, and Maintaining of Water-based Fire the deficient practice? Protection Systems. Records of system design, maintenance, inspection and testing are It is the facilities practice to maintained in a secure location and readily provide maintenance, testing and available. maintenance of the automatic a) Date sprinkler system last checked sprinkler and standpipe system that effect all 21 smoke b) Who provided system test compartments. The facility scheduled a 5 year c) Water system supply source sprinkler gauge

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Provide in REMARKS information on coverage for

any non-required or partial automatic sprinkler

This STANDARD is not met as evidenced by:

9.7.5, 9.7.7, 9.7.8, and NFPA 25

Event ID: #YY21

Facili

sheet Page 5 of 10

The facility scheduled relocation of the sprinkler head that was within 4inches of the wall in room 126 on 6/7/2017. The relocation is to be completed by a certified state licensed installer by 6/30/2017.

calibration/replacement effecting

all 21 smoke compartments by a certified state licensed inspector

calibration/replacement was

conducted on 6/13/2017.

on 6/7/2017. The

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/08/2017 FORM APPROVED

(X5) COMPLETION

DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 445017 B. WING NAME OF PROVIDER OR SUPPLIER 06/06/2017 STREET ADDRESS, CITY, STATE, ZIP CODE ASBURY PLACE AT MARYVILLE 2648 SEVIERVILLE RD MARYVILLE, TN 37804 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID

REGULATORY OR LSC IDENTIFYING INFORMATION)

K 353 Continued From page 5

PREFIX

TAG

Based on observation, record review and interview, the facility failed to maintain the automatic sprinkler system. This deficiency affected all 21 smoke compartments.

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

NFPA 101, 19.3.5 NFPA 13, 8.6.3.3

The findings include:

Observation, record review and interview with the maintenance director on 6/5/17 at 9:05 PM revealed:

- The 5 year sprinkler gauge calibration/replacement had not been conducted.
- Room 126 has a sprinkler within 4 inches of the wall.

The maintenance director was present when the deficiencies were identified and acknowledged by the administrator during the exit conference on 6/6/17

K 363 NFPA 101 Corridor - Doors

SS=D

Corridor - Doors 2012 EXISTING

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on

K 353

ID

PREFIX

TAG

2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

100% of all sprinkler heads have been inspected by the Facilities Director and no additional deficient sprinklers were found.

3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.

The Facilities Director will educate all maintenance staff regarding smoke compartments, sprinkler calibration/replacement and how to inspect them by June 30, 2017

K-363

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place.

Maintenance, Testing and maintain of the automatic sprinkler and standpipe system that effects all 21 smoke compartments for 5 year sprinkler gauge calibration/replacement will be conducted every 5 years on an ongoing basis as part of the routine

inspection schedule, by the facility eet Page 6 of 10 director or maintenance assistant. The results of the next check will be reported to the QAPI committee at the next meeting following the inspection.

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Event ID:34YY21

Facility ID

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/08/2017

| CENTER | S FOR MEDICARE | & MEDICAID SERVICES | | | FORM APPROVED OMB NO. 0938-039 | |
|---|--------------------------------------|---|--|---|-----------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | (X3) DATE SURVEY COMPLETED | |
| | | 445017 | B. WING | | 00/00/0045 | |
| | ROVIDER OR SUPPLIER PLACE AT MARYVIL | LE | | STREET ADDRESS, CITY, STATE, ZIP CODE 2648 SEVIERVILLE RD MARYVILLE, TN 37804 | 06/06/2017 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT | JLD BE COMPLETION | |

K 363 Continued From page 6

corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted.

Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.

19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485

Show in REMARKS details of doors such as fire protection ratings, automatics closing devices.

This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridor doors. This deficiency affected 2 of 21 smoke compartments.

NFPA 101, 19.6.3.5

The findings include:

Observation and interview with the maintenance director on 6/5/17 between 7:35 PM and 10:00 PM revealed resident room doors 123 and 238 failed to close to a positive latch.

The maintenance director was present when the deficiencies were identified and acknowledged by the administrator during the exit conference on 6/6/17.

K 918 NFPA 101 Electrical Systems - Essential Electric

K 363

K 363 Corridor- Doors

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

It is the facilities practice to ensure that we maintain Corridor Doors insuring positive latching for 2 of the 21 smoke compartments. The facility inspected the doors on 6/6/2017 at resident room 123 and 238 that failed to close and positive latch. Work to create positive latching at resident room door 123 and 238 that effects 2 of the 21 smoke compartments will be completed by 6/30/2017.

2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

100% compliance was noted for the other 19 smoke compartments.

3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.

The Facilities Director will educate all maintenance staff regarding positive latching of all doors and how to inspect them by June 30, 2017

sheet Page 7 of 10

.K-918

(X5)

COMPLETION

DATE

From:8659840655 06/22/2017 11:21 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/08/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 445017 NAME OF PROVIDER OR SUPPLIER 06/06/2017 STREET ADDRESS, CITY, STATE, ZIP CODE **ASBURY PLACE AT MARYVILLE** 2648 SEVIERVILLE RD MARYVILLE, TN 37804 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ΙĎ PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 363 How the corrective action(s) will K 918 Continued From page 7 be monitored to ensure the K.948 SS=D Syste deficient practice will not recur; i.e. what quality assurance Electrical Systems - Essential Electric System program will be put into place. Maintenance and Testing The generator or other alternate power source Positive door latching in all 21 and associated equipment is capable of supplying smoke compartments will be service within 10 seconds. If the 10-second criterion is not met during the monthly test, a checked monthly on an ongoing process shall be provided to annually confirm this basis as part of our routine capability for the life safety and critical branches. inspection schedule, by the facility Maintenance and testing of the generator and director or maintenance assistant. transfer switches are performed in accordance The results of the monthly checks with NFPA 110. Generator sets are inspected weekly, exercised

K-918

K 918 Electrical Systems- Essential **Electrical Systems**

committee x 3 months.

will be reported to the QAPI

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the facilities practice to ensure that we maintain Electrical Systems that affects 1 of 21 smoke compartments. The facility inspected the generator room on the south wing on 6/6/2017. All storage items placed in the generator room during that time was removed on 6/7/2017.

2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. 100% compliance was noted for

> other Electrical Systems that affect the 21 smoke compartments.

eet Page 8 of 10

stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain generators. This deficiency affected 1 0f 21 smoke compartments.

under load 30 minutes 12 times a year in 20-40

day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test

under load conditions include a complete

simulated cold start and automatic or manual

transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of

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Event ID: (4YY21

Facility

From:8659840655 06/22/2017 11:22 #571 P.015/017 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/08/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 445017 NAME OF PROVIDER OR SUPPLIER 06/06/2017 STREET ADDRESS, CITY, STATE, ZIP CODE ASSURY PLACE AT MARYVILLE 2648 SEVIERVILLE RD MARYVILLE, TN 37804 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID 1D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 3. What measures will be put into K 918 Continued From page 8 K 918 place or what systematic changes you will make to ensure that the NFPA 101, 19.7.6 deficient practice does not recur. NFPA 110, 7.11.1 The Facilities Director will educate The finding includes: all maintenance staff regarding no Observation and interview with the maintenance storage of any items in the director on 6/5/17 at 10:18 PM revealed the generator rooms by June 30, 2017 generator room on the South wing was being used for storage. 4. How the corrective action(s) will be monitored to ensure the The maintenance director was present when the deficient practice will not recur: deficiencies were identified and acknowledged by i.e. what quality assurance the administrator during the exit conference on program will be put into place. 6/6/17. K 923 NFPA 101 Gas Equipment - Cylinder and K 923 The facility will inspect the SS=D Container Storag generator room ensuring to maintain area without storage Gas Equipment - Cylinder and Container Storage during our weekly routine Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and inspection schedule, by the facility ventilated in accordance with 5.1.3.3.2 and director or maintenance assistant. 5.1.3.3.3. >300 but <3,000 cubic feet This will be done on an ongoing Storage locations are outdoors in an enclosure or basis and reported to the QAPI within an enclosed interior space of non- or committee x 3 months. limited-combustible construction, with door (or K 923 Gas Equipment- Cylinder gates outdoors) that can be secured. Oxidizing and Container Storage gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if 1. What corrective action(s) will be sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum accomplished for those residents 1/2 hr. fire protection rating. found to have been affected by Less than or equal to 300 cubic feet the deficient practice? In a single smoke compartment, individual

FORM CMS-2587(02-99) Previous Versions Obsolete

cylinders available for immediate use in patient

or equal to 300 cubic feet are not required to be

care areas with an aggregate volume of less than

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It is the facilities practice to ensure

that we maintain Gas Equipment-

Cylinder and Container Storage and proper signage that effect 2 of

21 smoke compartments .The

6/16/2017. Signage will be

storage area by 6/30/2017.

facility inspected and ordered the required signage for the Oxygen storage on 1 North and 2 North on

installed at the 1 North and 2 North

| DEPAR | TMENT OF HEALTH | AND HUMAN SERVICES | | | | | D: 06/08/201 AAPPROVE |
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| CENTE | KS FUR MEDICARE | & MEDICAID SERVICES | | | | | 0.0938-039 |
| AND PLAN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION - MAIN BUILDING 01 | (X3) DA | TE SURVEY MPLETED |
| NAME OF | SDOVIDES OF CLOSE (ST | 445017 | B. WING | | ··· | 06 | /06/2017 |
| | PROVIDER OR SUPPLIER PLACE AT MARYVIL | LE | | 264 | REET ADDRESS, CITY, STATE, ZIP CODE 8 SEVIERVILLE RD RYVILLE, TN 37804 | <u> </u> | 777777 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | < | FROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF | D RE | (X5) COMPLETION DATE |
| K 923 | A precautionary sign each door or gate of where the sign inclu | ure. Cylinders must be altions as specified in 11.6.2. In readable from 5 feet is on f a cylinder storage room, des the wording as a N: OXIDIZING GAS(ES) | К9 | 23 | The facility inspected and determined to relocate the Mair storage area from 1 North to the North dock area to maintain a noncombustible storage area for cylinders. A quote was acquired 6/12/2017 by fencing company t | 2 1 | |

Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain oxygen storage areas. This deficiency affected 2 of 21 smoke compartments. NFPA 101, 19.7.6 NFPA 99, 11.3.4,2

The findings include:

Observation and interview with the maintenance director on 6/5/17 between 8:22 PM and 9:45 PM revealed:

- The main oxygen storage room and the oxygen storage on 2N did not have the required signage.
- 2. The main oxygen storage room had combustibles stored within 5 feet of cylinders.

The maintenance director was present when the deficiencies were identified and acknowledged by the administrator during the exit conference on 6/6/17.

relocate and install fencing on 6/16/2017. Permanent storage for the main storage area will be completed on 6/30/2017.

2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

> 100% compliance was noted for other storage areas with in the 21 smoke compartments.

3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.

> The Facilities Director will educate all central supply, nursing, housekeeping, and maintenance staff regarding proper oxygen storage and signage of by June 30, 2017

#571 P.017/017

PRINTED: 06/08/2017 FORM APPROVED

| Division of Health Care Fac | ilities | | | FORM APPRO |
|--|---|---------------------------------------|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION 01 - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED |
| | TN0505 | B. WING | | 06/06/2017 |
| NAME OF PROVIDER OR SUPPLIER | STREET A | DRESS, CITY, S | STATE, ZIP CODE | 7 00/00/2011 |
| ASBURY PLACE AT MARYVIL | LE 2648 SE | /IERVILLE RI LE, TN 3780 | D | |
| PREFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | DULD BE COMPI |
| conducted ph 6/5 & | portion of the survey 6/6/17, no deficiencies were 6 standards for nursing | N 002 | 4. How the corrective actions be monitored to ensure the deficient practice will not rive, what quality assurance program will be put into play the facility will inspect the Company to maintain a without combustible material proper signage during our warroutine inspection schedule, facility director or maintenant assistant. These checks will be done on an ongoing basis and be reported to the QAPI committee x 3 months. | ecur; ace. Sas prage rea al and eekly by the ce |
| n of Health Care Facilities | | · · · · · · · · · · · · · · · · · · · | | |
| n of Health Care Facilities ATORY DIRECTOR'S OR PROVIDEGE FORM | SUPPLIER REPRESENTATIVE'S SIGNA | TURE | TITLE LNHA | (X6) DATE |